DR. CHERYL J. LAMPE, D.D.S., INC.

Modern Dentistry in a Smalltown Atmosphere

HEALTH HISTORY

Date _____ Patient Name _____ Name you wish to be called _____

Street Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Cell Phone _____

Best Time and Place to Reach You _____

Sex: M F Age _____ Birthdate _____ *(please circle)* Single | Married | Widowed | Separated | Divorced

Patient SS # _____ Email Address _____

Employer _____

Employer Address _____ Employer Phone _____

Spouse Name _____ Birthdate _____ SS# _____

Spouse's Employer _____

****

IN CASE OF EMERGENCY, PLEASE CONTACT *(someone not living with you)*

Name _____ Relationship to you _____

Address and Phone Number of Emergency Contact Person _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____ Relationship to patient _____

****

Insurance Company _____ Group # _____

Is patient covered by additional insurance? Yes No Subscriber's name _____

Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____

Employer _____ Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

367 S. Main St. Pataskala, Ohio 43062 • 740-927-4876 • www.CherylLampeDDS.com

Office Hours: Monday 9am - 6pm • Wednesday 9am - 5pm • Thursday 9am - 6pm • Friday 9am. - 1pm

DR. CHERYL J. LAMPE, D.D.S., INC.

Modern Dentistry in a Smalltown Atmosphere

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

Please circle Yes or No to indicate if you have had any of the following:

Bad Breath	Yes No	Sensitivity to:		Grinding teeth	Yes No
Burning Sensation on		* Hot	Yes No	Orthodontic treatment	Yes No
tongue	Yes No	* Cold	Yes No	Do you like your smile?	Yes No
Clicking or popping jaw	Yes No	* Sweets	Yes No	Had a serious or difficult	
Jaw pain	Yes No	* Biting	Yes No	problem with previous	
Jaw tiredness	Yes No	Dry mouth	Yes No	dental treatment?	Yes No
Food collection between		Mouth Breather	Yes No	How often do you brush?	_____
teeth	Yes No	Cold sores/Blisters	Yes No	How often do you floss?	_____
Loose teeth or broken		Smoking/Tobacco	Yes No	Types of bristles you use: *(please check)*	
fillings	Yes No	Chew Tobacco	Yes No	Soft [ ] Medium [ ] Hard [ ]	
Pain around ear	Yes No	Nail biting	Yes No		
Bleeding/swollen gums	Yes No	Lip/Cheek biting	Yes No		

ADDITIONAL NOTES

367 S. Main St. Pataskala, Ohio 43062 • 740-927-4876 • www.CherylLampeDDS.com

Office Hours: Monday 9am - 6pm • Wednesday 9am - 5pm • Thursday 9am - 6pm • Friday 9am. - 1pm

Time 11:48 AM

Cheryl J. Lampe, D.D.S, Inc..

Date 3/13/2019

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

DR. CHERYL J. LAMPE, D.D.S., INC.

Modern Dentistry in a Smalltown Atmosphere

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be infolved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing amore complete description of the used and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient (if patient is minor): _____

Signature: _____

Date: _____

****

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

367 S. Main St. Pataskala, Ohio 43062 • 740-927-4876 • www.CherylLampeDDS.com
Office Hours: Monday 9am - 6pm • Wednesday 9am - 5pm • Thursday 9am - 6pm • Friday 9am. - 1pm

Financial Policy

Cheryl Lampe, D.D.S., Inc.

367 S. Main St. P O Box 780

Pataskala, OH 43062

740-927-4876

This is an agreement between the dental practice of Cheryl Lampe DDS, Inc. and the patient. By signing this financial policy you are agreeing to pay for all services that are received.

PAYMENT for dental services provided by our practice is the total responsibility of the patient and is due at the time of service. We accept cash, check, debit and credit cards.

INSURANCE is a contract between you and your insurance company. We are NOT a party to this contract. We will submit dental claims to your insurance company as a courtesy to you. Most insurance companies pay only a portion of the cost of your treatment. Any insurance quotes given from this office are estimates. You are responsible for any portion of the fees not paid by your insurance company. All estimated co-payments and deductibles will be collected at the time of service.

PAYMENT PLANS: We **DO NOT** make in house payment arrangements. However, we do offer financing through Care Credit. Please see office manager for more details.

RETURNED CHECKS: There is a fee of $30 for any returned checks by the bank.

PAST DUE ACCOUNTS: If your account becomes past due, we will make necessary steps to collect this debt. If we have to refer your account to a collection agency, you will be responsible for the collection costs incurred. If we have to refer to collection to an attorney you will be responsible for all attorney fees incurred, plus all court costs.

MISSED APPOINTMENTS: Your time is valuable, as is ours. An appointment is time reserved especially for you. It is also a block of time reserved for our staff and facilities to treat you. We ask for your consideration in giving us a minimum of 24 hours' notice for the cancellation of an appointment. We understand that emergencies and last minute problems may arise, however your prompt notification will allow us to fill that appointment. We reserve the right to charge you for cancelled or missed appointments. If you fail to show for three appointments without notifying our office we reserve the right to terminate the patient-doctor relationship.

Signature _____ Date _____

Printed Name _____ Office Witness _____

*Copy available upon request